

		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0038943</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>SOUTHVIEW MANOR</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2002</u> to <u>12/31/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>																																																	
Address: <u>3311 S. MICHIGAN AVE.</u> <u>CHICAGO</u> <u>60616</u>																																																			
Number City Zip Code																																																			
County: <u>COOK</u>																																																			
Telephone Number: <u>(847) 326-9101</u> Fax # <u>(847) 326-6187</u>																																																			
IDPA ID Number: <u>36-3924792</u>																																																			
Date of Initial License for Current Owners: <u>12/16/93</u>																																																			
Type of Ownership:																																																			
<table><tr><td><input type="checkbox"/></td><td>VOLUNTARY, NON-PROFIT</td><td><input checked="" type="checkbox"/></td><td>PROPRIETARY</td><td><input type="checkbox"/></td><td>GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input type="checkbox"/></td><td>County</td></tr><tr><td><input type="checkbox"/></td><td></td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other</td></tr><tr><td><input type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td>"Sub-S" Corp.</td><td><input type="checkbox"/></td><td></td></tr><tr><td><input type="checkbox"/></td><td></td><td><input type="checkbox"/></td><td>Limited Liability Co.</td><td><input type="checkbox"/></td><td></td></tr><tr><td><input type="checkbox"/></td><td></td><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td></td></tr><tr><td><input type="checkbox"/></td><td></td><td><input type="checkbox"/></td><td>Other</td><td><input type="checkbox"/></td><td></td></tr></table>		<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL	<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State	<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County	<input type="checkbox"/>		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other	<input type="checkbox"/>		<input checked="" type="checkbox"/>	"Sub-S" Corp.	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	Limited Liability Co.	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	Trust	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	Other	<input type="checkbox"/>			
<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL																																														
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State																																														
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County																																														
<input type="checkbox"/>		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other																																														
<input type="checkbox"/>		<input checked="" type="checkbox"/>	"Sub-S" Corp.	<input type="checkbox"/>																																															
<input type="checkbox"/>		<input type="checkbox"/>	Limited Liability Co.	<input type="checkbox"/>																																															
<input type="checkbox"/>		<input type="checkbox"/>	Trust	<input type="checkbox"/>																																															
<input type="checkbox"/>		<input type="checkbox"/>	Other	<input type="checkbox"/>																																															
IRS Exemption Code _____																																																			
In the event there are further questions about this report, please contact:																																																			
Name: <u>BOB KAGDA</u>		Telephone Number: <u>(847) 675-3585</u>																																																	

Officer or Administrator of Provider	(Signed) _____	(Date) _____	
	(Type or Print Name) <u>SHELDON NEIDICH</u>		
Paid Preparer	(Title) <u>OFFICER</u>		
	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	
	(Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u>		
	(Firm Name & Address) <u>KRUPNICK BOKOR KAGDA & BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u>		
	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>		
		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number SOUTHVIEW MANOR # 0038943 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>74</u>	Skilled (SNF)	<u>74</u>	<u>27,010</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>126</u>	Intermediate (ICF)	<u>126</u>	<u>45,990</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>200</u>	TOTALS	<u>200</u>	<u>73,000</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>68,302</u>	<u>5</u>	<u>251</u>	<u>68,558</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>68,302</u>	<u>5</u>	<u>251</u>	<u>68,558</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 93.92%

D. How many bed-hold days during this year were paid by Public Aid?
_____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 12/16/93

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date 12/16/93 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SOUTHVIEW MANOR # 0038943 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	196,186	26,402	12,674	235,262		235,262		235,262			1
2	Food Purchase		221,895		221,895		221,895	(524)	221,371			2
3	Housekeeping	188,658	30,918		219,576		219,576		219,576			3
4	Laundry	58,411	17,149	3,931	79,491		79,491		79,491			4
5	Heat and Other Utilities			162,190	162,190		162,190		162,190			5
6	Maintenance	80,784	27,564	52,744	161,092		161,092		161,092			6
7	Other (specify):* security	41,926		16,327	58,253		58,253		58,253			7
8	TOTAL General Services	565,965	323,928	247,866	1,137,759		1,137,759	(524)	1,137,235			8
	B. Health Care and Programs											
9	Medical Director			6,800	6,800		6,800		6,800			9
10	Nursing and Medical Records	1,609,765	45,542	19,322	1,674,629		1,674,629		1,674,629			10
10a	Therapy	44,804	208	10,901	55,913		55,913		55,913			10a
11	Activities	94,443	34,891	2,962	132,296		132,296		132,296			11
12	Social Services	136,936		8,753	145,689		145,689		145,689			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,885,948	80,641	48,738	2,015,327		2,015,327		2,015,327			16
	C. General Administration											
17	Administrative	156,428		37,800	194,228		194,228	(37,800)	156,428			17
18	Directors Fees											18
19	Professional Services			26,139	26,139		26,139	10,251	36,390			19
20	Dues, Fees, Subscriptions & Promotions			74,121	74,121		74,121	(34,332)	39,789			20
21	Clerical & General Office Expenses	65,870	27,081	34,538	127,489		127,489	(457)	127,032			21
22	Employee Benefits & Payroll Taxes			465,250	465,250		465,250		465,250			22
23	Inservice Training & Education			900	900		900		900			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			184,145	184,145		184,145		184,145			26
27	Other (specify):*											27
28	TOTAL General Administration	222,298	27,081	822,893	1,072,272		1,072,272	(62,338)	1,009,934			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,674,211	431,650	1,119,497	4,225,358		4,225,358	(62,862)	4,162,496			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			31,114	31,114		31,114	148,571	179,685			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			77,194	77,194		77,194	489,298	566,492			32
33	Real Estate Taxes			274,815	274,815		274,815		274,815			33
34	Rent-Facility & Grounds			672,000	672,000		672,000	(672,000)				34
35	Rent-Equipment & Vehicles			57,245	57,245		57,245		57,245			35
36	Other (specify):* see schedule			249,066	249,066		249,066	(240,000)	9,066			36
37	TOTAL Ownership			1,361,434	1,361,434		1,361,434	(274,131)	1,087,303			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			109,500	109,500		109,500		109,500			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,674,211	431,650	2,590,431	5,696,292		5,696,292	(336,993)	5,359,299			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,517)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(524)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(457)	21		18
19	Entertainment		20		19
20	Contributions	(4,986)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(29,346)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(277,800)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (318,630)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(18,363)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (18,363)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (336,993)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$	6	1
2	GOODWILL	(240,000)	36	2
3	NON ALLOWABLE MANAGEMENT FEES	(37,800)	17	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(277,800)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SOUTHVIEW MANOR# 0038943

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(524)	0	0	0	0	0	0	0	0	0	0	(524)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(524)	0	0	0	0	0	0	0	0	0	0	(524)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(37,800)	0	0	0	0	0	0	0	0	0	0	(37,800)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,251	0	0	0	0	0	0	0	0	0	10,251	19
20	Fees, Subscriptions & Promotions	(34,332)	0	0	0	0	0	0	0	0	0	0	(34,332)	20
21	Clerical & General Office Expenses	(457)	0	0	0	0	0	0	0	0	0	0	(457)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(72,589)	10,251	0	0	0	0	0	0	0	0	0	(62,338)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(73,113)	10,251	0	0	0	0	0	0	0	0	0	(62,862)	29

Summary B

12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		LIST ATTACHED		E&N PARTNERSHIP	CHICAGO	REAL ESTATE
				EXTENDED CARE	CHICAGO	EMPLOYEE LEAS

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 672,000	E & N LIMITED PARTNERSHIP		\$	(672,000)	1
2	V	19	PROFESSIONAL FEES		E & N LIMITED PARTNERSHIP	100.00%	10,251	10,251	2
3	V	30	SL-DEPREC.BUILD		E & N LIMITED PARTNERSHIP	100.00%	104,088	104,088	3
4	V	30	SL-DEPREC.EQUIPMENT		E & N LIMITED PARTNERSHIP	100.00%	50,000	50,000	4
5	V	32	INTEREST-ALBANK		E & N LIMITED PARTNERSHIP	100.00%	314,548	314,548	5
6	V	32	INTER-SHELDON NEIDICH		E & N LIMITED PARTNERSHIP	100.00%	174,750	174,750	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 672,000			\$ 653,637	\$ * (18,363)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SHELDON NEIDICH	PRESIDENT	Administration	42.50	westshire-\$164500	20	36.40	INT EXPENSE	\$ 174,750	32-8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 174,750		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SOUTHVIEW MANOR # 0038943 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization E & N LIMITED PARTNERSHIP
Street Address 3322 S. MICHIGAN AVE.
City / State / Zip Code CHICAGO, IL 60616
Phone Number (847) 326-9101
Fax Number (847) 326-6187

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	DIRECT	1	1	\$ 10,251	\$	1	\$ 10,251	1
2	30	DEPRECIATION	DIRECT	1	1	154,088		1	154,088	2
3	32	INTEREST	DIRECT	1	1	489,298		1	489,298	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 653,637	\$		\$ 653,637	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	ALBANY BANK		X	MORTGAGE	\$37,160.00	7/1/96	\$ 4,713,000	\$ 4,208,615	06/15/06	0.0825	\$ 314,548	1	
2	SHELDON NEIDICH	X		MORTGAGE	INT ONLY		2,475,000	2,475,000			174,750	2	
3												3	
4												4	
5												5	
	Working Capital												
6	ALBANY BANK		X	WORKING CAPPITAL	VARIES		1,200,000	1,424,999	REVOLV		65,684	6	
7	OMI			INTEREST ONLY				139,000			4,000	7	
8	PETERSON BANK		X	INSURANCE INTEREST							7,510	8	
9	TOTAL Facility Related				\$37,160.00		\$ 8,388,000	\$ 8,247,614			\$ 566,492	9	
	B. Non-Facility Related*												
10	IRS, IDR, ETC		X	LATE FEES								10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 8,388,000	\$ 8,247,614			\$ 566,492	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	257,634	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	266,344	2
3. Under or (over) accrual (line 2 minus line 1).			\$	8,710	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	266,344	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	(239)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	274,815	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1997 267,179 8			
		1998 271,922 9			
		1999 265,101 10			
		2000 257,634 11			
		2001 266,344 12			
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL		FOR OHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2001	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SOUTHVIEW MANOR COUNTY COOK
FACILITY IDPH LICENSE NUMBER 0038943
CONTACT PERSON REGARDING THIS REPORT BOB KAGDA
TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 17-34-116-008-0000	NURSING HOME	\$ 2,010.30	\$ 2,010.30
2. 17-34-116-007-0000	NURSING HOME	\$ 39,817.41	\$ 39,817.41
3. 17-34-116-006-0000	NURSING HOME	\$ 39,817.41	\$ 39,817.41
4. 17-34-116-005-0000	NURSING HOME	\$ 39,817.41	\$ 39,817.41
5. 17-34-116-004-0000	NURSING HOME	\$ 52,531.98	\$ 52,531.98
6. 17-34-116-003-0000	NURSING HOME	\$ 92,349.92	\$ 92,349.92
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 266,344.43	\$ 266,344.43

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet: 91,960

B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 145,695	1
2					2
3	TOTALS			\$ 145,695	3

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	200		1993		\$ 4,059,425	\$ 104,088	39	\$ 104,088	\$	\$ 941,136	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT			1994	4,931	126	39	126		1,076	9
10	HEAT EXCHANGER			1995	4,895	126	39	126		992	10
11	TUB-PLUMBING			1995	11,279	289	39	289		2,276	11
12	WINDOWS			1995	613	16	39	16		121	12
13	BOILER			1995	5,239	134	39	134		988	13
14	DOOR REPLACEMENT			1996	4,397	113	39	113		748	14
15	DOOR RESTRICTORS ON ELEVATORS			1997	3,042	78	39	78		432	15
16	ALARM SYSTEM			1997	3,664	94	39	94		521	16
17	SAFETY GLASS			1997	2,099	54	39	54		299	17
18	HEATER EXHAUST STACK			1998	3,185	81	39	81		375	18
19	AIR DUCTS			1998	3,085	79	39	79		366	19
20	ACCESS PANELS			1998	2,466	63	39	63		276	20
21	HEAT EXCHANGER			1995	8,440	216	39	216		945	21
22	AIR DUCTS			1998	3,298	85	39	85		372	22
23	FIRE DAMPERS			1998	24,840	637	39	637		2,628	23
24	ACCESS PANELS			1998	2,724	70	39	70		289	24
25	FIRE PANELS			1998	1,264	33	39	33		136	25
26	BOILER			1999	4,830	124	39	124		439	26
27	FIRE DAMPERS			1999	8,280	212	39	212		751	27
28	ELEVATOR IMPROVEMENT			1999	5,000	128	39	128		453	28
29	FIRE DOORS			1999	5,535	142	39	142		503	29
30	SPRINKLER SYSTEM			1999	3,945	101	39	101		358	30
31	NEW ROOF			2000	7,000	255	27.5	255		648	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.
 See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$4,183,476	\$107,344		\$107,344	\$	\$957,128	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$218,799	\$23,791	\$21,879	\$(1,912)	10 YRS	\$121,825	71
72	Current Year Purchases	9,244	4,067	462	(3,605)	10 YRS	462	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	500,000	50,000	50,000		10 YRS	454,166	74
75	TOTALS	\$728,043	\$77,858	\$72,341	\$(5,517)		\$576,453	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$5,057,214	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$185,202	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$179,685	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(5,517)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,533,581	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$44,365 Description: SEE SCHEDULE ATTACHED
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY VAN	98 FORD VAN	\$605.00	\$9,800	17
18	ADMINISTRATATION	03 JAGUAR	770.00	3,080	18
19					19
20					20
21	TOTAL		\$1,375.00	\$12,880	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
12. /2003 \$
13. /2004 \$
14. /2005 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 120,615	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,714,552		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,126		6
7	Other Prepaid Expenses	4,416		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,888,709	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	124,051		15
16	Equipment, at Historical Cost	283,948		16
17	Accumulated Depreciation (book methods)	(256,633)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): NET GOODWILL	1,419,600		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,570,966	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,459,675	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 551,884	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,424,999		29
30	Accrued Salaries Payable	77,372		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,919		31
32	Accrued Real Estate Taxes(Sch.IX-B)	266,344		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO RELATED PARTIES	378,170		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,704,688	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,000,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,000,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,704,688	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 754,987	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,459,675	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 572,446	1
2	Restatements (describe):		2
3	POST CLOSING ENTRIES	(5,015)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 567,431	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	187,556	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 187,556	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 754,987	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	1
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,883,848	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,883,848	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,883,848	30

	Expenses	Amount	2
	A. Operating Expenses		
31	General Services	1,137,759	31
32	Health Care	2,015,327	32
33	General Administration	1,072,272	33
	B. Capital Expense		
34	Ownership	1,361,434	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	109,500	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,696,292	40
41	Income before Income Taxes (line 30 minus line 40)**	187,556	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 187,556	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
 (This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,686	1,712	\$ 46,059	\$ 26.90	1
2	Assistant Director of Nursing	157	161	3,872	24.05	2
3	Registered Nurses	9,710	10,354	242,851	23.45	3
4	Licensed Practical Nurses	29,677	30,657	606,074	19.77	4
5	Nurse Aides & Orderlies	70,932	75,211	622,649	8.28	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,179	4,439	44,804	10.09	8
9	Activity Director	1,019	1,168	14,411	12.34	9
10	Activity Assistants	10,488	10,891	80,032	7.35	10
11	Social Service Workers	9,982	10,802	136,936	12.68	11
12	Dietician					12
13	Food Service Supervisor	1,727	1,768	29,355	16.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,242	22,522	166,831	7.41	15
16	Dishwashers					16
17	Maintenance Workers	4,576	4,984	80,784	16.21	17
18	Housekeepers	20,878	22,867	188,658	8.25	18
19	Laundry	7,917	8,265	58,411	7.07	19
20	Administrator	2,046	2,086	78,214	37.49	20
21	Assistant Administrator	2,046	2,086	78,214	37.49	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,614	5,191	65,870	12.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,007	2,142	32,891	15.36	31
32	Other Health C:HR&nrsrg clerk	3,897	4,170	55,369	13.28	32
33	Other(specify) security	5,114	5,201	41,926	8.06	33
34	TOTAL (lines 1 - 33)	213,894	226,677	\$ 2,674,211 *	\$ 11.80	34

* This total must agree with page 4, column 1, line 45.
 ** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 7,480	1-3	35
36	Medical Director	O	6,800	9-3	36
37	Medical Records Consultant	N	4,233	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	3,684	10-3	39
40	Physical Therapy Consultant	L	3,285	10a-3	40
41	Occupational Therapy Consultant	Y	5,740	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,962	11-3	44
45	Social Service Consultant	E	6,177	12-3	45
46	Other(specify)	S			46
47	MDS Care Plan Consultant		11,105	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 51,466		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number **SOUTHVIEW MANOR**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	Ownership %	Amount
ZINA WARD	ADMIN		\$ 78,214
ALBERTA HALL	ASST ADMIN		78,214
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 156,428
B. Administrative - Other			
Description			Amount
HUNTER - MANAGEMENT FEES			\$ 37,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 37,800
C. Professional Services			
Vendor/Payee	Type		Amount
HDSI	DATA PROCESSING		\$ 4,250
KRUPNICK BOKOR	ACCOUNTING		21,036
PERSONNEL PLANNERS	UC CONSULTANT		853
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 26,139
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 28,064
Unemployment Compensation Insurance			28,038
FICA Taxes			208,791
Employee Health Insurance			189,187
Employee Meals			#REF!
Illinois Municipal Retirement Fund (IMRF)*			
EMPLOYEE BENEFITS - OTHER			5,254
EMPLOYEE PHYSICAL EXAMS			0
PENSION/PROFIT SHARING PLANS			0
CHICAGO HEAD TAX			5,916
INSURANCE - EXECUTIVE LIFE			0
INSURANCE - EXECUTIVE LIFE VI 21			0
TOTAL (agree to Schedule V, line 22, col.8)			\$ #REF!
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 400
Advertising: Employee Recruitment			27,152
Health Care Worker Background Check (Indicate # of checks performed)			3,040
MARKETING/ADV/PROMO			29,346
TRUST/FRANCHISE/CONTRIB/ETC			4,986
LICENSES & PERMITS			1,533
DUES & SUBSCRIPTIONS			7,664
MGMT CO ALLOCATION			
TRUST/FRANCHISE/CONTRIB/ETC			(4,986)
Less: Public Relations Expense			(0)
Non-allowable advertising			(29,346)
Yellow page advertising			(0)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 39,789
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
			0
Seminar Expense			
			0
Entertainment Expense			()
TOTAL (agree to Sch. V, line 24, col. 8)			\$

*** Attach copy of IMRF notifications**

****See instructions.**

(See instructions.)

[illegible]

Facility Name & ID Number SOUTHVIEW MANOR

0038943

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$11,400
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 109,500
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ #REF! Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: SOUTHVIEW MANOR

#0038943

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	7,480
	REPAIRS & MAINTENANCE	5,194
		0
		12,674
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	3,931
		0
		3,931
5	HEAT & OTHER UTILITIES	
	GAS HEAT	47,404
	ELECTRICITY	60,250
	WATER	54,536
	CABLE TV - LOBBY	0
		0
		162,190
6	MAINTENANCE	
	GROUNDS MAINTENANCE	0
	PAINTING & DECORATING	0
	BUILDING REPAIRS	12,032
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	6,494
	ELEVATOR MAINTENANCE & REPAIR	18,908
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,033
	FIRE SERVICE	11,277
		0
		0
		0
		52,744
7	OTHER	
	SCAVENGER	16,327
	SECURITY SERVICE	0
		16,327
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,800
		6,800

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,233
	PHARMACY CONSULTANT XVIII B 39-2	3,684
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
	DENTAL SERVICES	300
	MDS CARE PLAN CONSULTANT	11,105
		19,322
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	728
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	1,148
	REHABILITATION CONSULTANT XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	3,285
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	5,740
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		10,901
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,962
		0
		2,962
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	2,576
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	6,177
	SOCIAL WORKER XVIII B 45-2	0
		0
		8,753
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	37,800
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	4,250
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	21,889
		0
		26,139
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	29,346
	EMPLOYEE WANT ADS XIX F	27,152
	CONTRIBUTIONS VI 20 XIX F	1,250
	DUES & SUBSCRIPTIONS XIX F	7,664
	LICENSES & PERMITS XIX F	1,933
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,736
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	3,040
		74,121
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	967
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	457
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	30,732
	MESSENGER SERVICE	2,382
		0
		34,538

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	208,791
	UNEMPLOYMENT COMPENSATION XIX D	28,038
	WORKERS COMPENSATION INSURANC XIX D	28,064
	HOSPITALIZATION INSURANCE XIX D	189,187
	EMPLOYEE BENEFITS - OTHER XIX D	5,254
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	5,916
		465,250
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	900
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	0
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	184,145
27	OTHER	
	BAD DEBTS VI 24	0
		0
		0

GRAND TOTAL COLUMN 3 OTHER

1,119,497